RI Department of Health
PO Box 1615
Providence, RI 02901-1615
www.healthri.org

RI Department of Health

Application and Instructions for:

Food Safety Training Program

Applicant Name (Name of Business)

Previous Business Name & License Number (If Any)

OFFICE USE ONLY

	Initials	Date
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

INSTRUCTIONS

Attach the following in specified order:

A. Sources and locations of potential students, faculty, classrooms, and other resources

B. Names and qualifications of instructors (Attach copies of "Instructor Applications")

C. Copy of cirriculum, including any provision for practical experience

D. Copy of the course syllabus, which shall include:

1. Text books and other teaching materials used

2. Methods and locations used for instructions

3. Course content

4. Topics and length of class meeting

5. Methods used to determine students participation and presence during the course sessions, examples, sign-up sheets, roster, provisions for make up work, etc.

Submit completed application and documentation to:

Rhode Island Department of Health
Division of Food Protection
Food Manager Certification Program
Three Capitol Hill
Room 203
Providence, RI 02908-5097

If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.

State of Rhode Island and Providence Plantations
Department of Health
Office of Food Protection

Facility Name: Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name: _____
Course Coordinator: Please provide the name and telephone number of a person we can contact concerning this program.	Name: _____ Phone Number: ( ) _____
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website).**	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City,State, ZipCode _____ Country (only if not in US) _____ Phone: _____ Fax: _____ Email Address: _____
Facility Location Information: Please provide the location information for this facility. (P**ublished on HEALTH website)**	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City,State, ZipCode _____ Country (only if not in US) _____ Phone: _____ Fax: _____ Email Address: _____
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **Signature of Authorized Person** _____ **Date of Signature (MM/DD/YY)** _____ **Printed Name of Authorized Person** _____ **Title of Authorized Person** _____